

## **CALIFORNIA BRIDGE TO REFORM DEMONSTRATION**

### **CMS SPECIAL TERMS AND CONDITIONS (STCs)**

#### **DRAFT SUMMARY OF PROVISIONS AFFECTING LOW INCOME HEALTH PROGRAM (LIHP)**

##### **Introduction**

On November 2, 2010, the federal government approved California's five year, "Bridge to Reform" Section 1115 waiver proposal. Through the Section 1115 waiver, California will advance program changes that will help the state transition to the federal reforms that will take effect in January, 2014 related in particular to Medi-Cal expansion. This summary is based on the STCs, as currently written. The Department is currently working on technical corrections for inclusion before Federal Centers of Medicare and Medicaid Services (CMS) finalizes the STCs. Additionally, this summary is a working draft and information provided is subject to change due to technical corrections and/or development of policies and procedures by the Department.

##### **Scope**

The focus of this summary is the Special Terms and Conditions (STCs) set forth in communication from the CMS to the California Department of Health Care Services (DHCS) relating to the Low Income Health Programs (LIHP). DHCS is in the process of developing the detailed managed care requirements that will apply to LIHP. At the end of this document, a link to a sample Medi-Cal managed care contract, is provided with a list of contract attachments that may be applicable to LIHP as a sample.

The STCs for the LIHP are effective November 1, 2010 through December 31, 2013.

##### **General Financial Requirements**

##### **Low Income Health Program (LIHP)**

The LIHP consists of the Medicaid Coverage Expansion (MCE) and the Health Care Coverage Initiative (HCCI) programs. With respect to the receipt of federal reimbursement, the MCE differs from the HCCI. Under the MCE, there is broader range of services and no cap on federal reimbursement. In contrast, under HCCI, the range of services is narrower and there is a cap on federal reimbursement. (STC Page 19, Paragraph 42)

##### **LIHP Cost Claiming Protocols**

The State may not claim FFP prior to the approval of the funding and reimbursement protocols for the LIHP. (STC page 19, Paragraph 43)

The State will require that counties adhere to approved funding and reimbursement protocols, including the administrative cost claiming protocol for reimbursement of administrative costs. (STC Page 19, Paragraph 43)

The costs of services must be separately reported for the MCE and the HCCI, respectively. (STC Page 19, Paragraph 43)

### **LIHP Maintenance of Effort (MOE)**

The MOE requirement ensures that federal funds allocated to the participating counties supplement, and do not supplant, any county, city and county, health authority, state, or federal funds that otherwise would have been spent by the participating county on health care services. Participating counties comply with this requirement by demonstrating that the annual amount of non-federal funds expended by the participating contractor for health care services provided to the indigent are maintained at, or increased above, the level specified in the STCs.

(STC Page 20, Paragraph 44)

### **Low Income Health Program**

**Eligibility and Enrollment Process:** For both the MCE and HCCI programs, eligible individuals may not be otherwise eligible for Medicaid or CHIP, must be non-pregnant, and must meet income eligibility standards that are determined on a county-by-county basis, with variation in the eligibility standards between counties within ranges established under this Demonstration. An individual determined eligible in one participating county who moves to another participating county will be disenrolled by the county in which the individual is no longer a resident, and may apply in the county to which the individual becomes a resident. (Page 24, Paragraph 58)

### **MCE Applicants**

To be eligible for MCE, an applicant must be non-pregnant between 19 and 64 years of age who are not enrolled in Medicaid or CHIP and who appear to have family incomes at or below 133 percent of the federal poverty level (FPL) (or less based on participating county standards) who have completed an application in a participating county and who have not had an eligibility determination. (STC Page 24, Paragraph 58.a.i)

### **New MCE Recipients**

To be eligible as a new MCE recipient, an applicant must be between 19 and 64 years of age who have family incomes at or below 133 percent of the FPL (or less based on participating county standards), are not enrolled in or eligible for Medicaid or CHIP and who have been determined to be eligible for enrollment into a participating county program. (STC Page 25, Paragraph 58.a.ii.A)

### **Existing MCE Recipients**

Existing MCE recipients include certain individuals whose income is at or below 133 percent of the FPL, and who were enrolled in the “Medi-Cal Hospital/Uninsured Care Waiver” at the effective date of this Demonstration. (STC Page 25, Paragraph 58.a.ii.B)

**HCCI Applicants**

To be eligible for HCCI, an applicant must be a non-pregnant individual between 19 and 64 years of age who appears to have family incomes above 133 through 200 percent of the FPL (or less based on participating county standards), is not enrolled in Medicaid or CHIP, does not have third party coverage, who has completed an application for HCCI in a participating county and who has not had an eligibility determination. (STC Page 25, Paragraph 58.a.iii)

**HCCI New Recipients**

A new HCCI recipient is an individual between 19 and 64 years of age who have family incomes above 133 through 200 percent of the FPL (or less based on participating county standards), are not enrolled in or eligible for Medicaid or CHIP, do not have third party coverage, and who have been determined to be eligible for enrollment into a participating county. (STC Page 25, Paragraph 58.a.iv.A)

**New HCCI Recipient Enrollment Limitations**

New MCE applicants must be enrolled prior to new HCCI applicants. To be eligible for FFP, a county must not enroll new HCCI applicants at the exclusion of MCE applicants. (STC Page 25, Paragraph 58.a.iv.B)

**Existing HCCI Recipients**

Existing HCCI recipients include certain individuals whose income is above 133 through 200 percent of the FPL, and who were enrolled in the “Medi-Cal Hospital/Uninsured Care Waiver” at the effective date of this Demonstration. (STC Page 25, Paragraph 58.a.iv.C)

**Initial Eligibility Determination**

A participating county is authorized to make eligibility determinations on applications for MCE or HCCI. (STC Page 25, Paragraph 58.a.v)

**Baseline Income Limit Notice**

A county must determine the Baseline Income Limit for MCE and HCCI eligibility. In addition to the (A) actual upper income limit selected by the county, the county must determine (B) the actual/projected enrollment for MCE and HCCI, respectively (C) the projected expenditure for MCE and HCCI, respectively, and (D) any county-specific standards, methodologies or procedures to determine how applicant eligibility is determined for the MCE and HCCI programs. (STC Page 25, Paragraph 58.b.i. A-D)

**Adjustments to the Income Limit**

A county may reduce the income limit for new applicants if through budget projections, funding will not be adequate to enroll applicants under previously stated income levels (Paragraph 58.b.i). However, any reduction in income limits must ensure that lower income applicants remain eligible. Counties must also ensure that if upper income limits are reduced for MCE applicants, the county may not extend eligibility to HCCI applicants. (STC Page 26, Paragraph 58.b.ii)

**Enrollment Caps**

A county may set enrollment caps for the HCCI program if it determines that continued enrollment will exceed available funding. If enrollment caps close the HCCI program to new enrollment and the county estimates that it will still exceed available funding, the county may also set enrollment caps for the MCE population. (STC Page 26, Paragraph 58.c)

**Wait Lists for MCE and HCCI Applicants**

The State has the option to use county-based wait lists to manage individual applicant enrollment in the county HCCI or MCE program. (STC Page 26, Paragraph 58.d)

**Outreach for those on the Wait Lists**

The counties will be required to maintain contact with wait-listed persons for at least six months and afford them opportunity to sign up for other programs and distribute written materials regarding application for Medi-Cal and CHIP. (STC Page 26, Paragraph 58.e)

**Eligibility Determination**

The counties may decide which merit employees will make eligibility determinations. While counties may develop eligibility income standards, methodologies and procedures for the MCE and HCCI populations, there must be compliance with specified Federal statutes, including those for documentation of immigration status. (STC Page 26, Paragraph 59.a-b)

**Eligibility Redetermination**

Counties will be required to conduct an annual eligibility redetermination for each MCE or HCCI recipient, including reassessment for Medi-Cal and CHIP. If the county has current eligibility standards that are more restrictive than when a MCE or HCCI recipient was initially enrolled that individual continues to be eligible under the county's initial eligibility standards. The MCE or HCCI recipient may apply for eligibility under Medi-Cal or CHIP at any time. (STC Page 26, Paragraph 60.a-b)

**Retroactive Eligibility**

The county has the option to extend up to 3 month retroactive eligibility for the MCE population. If health care costs were incurred during those months, FFP would be available. (STC Page 27, Paragraph 61)

**Disenrollment of Recipients**

The MCE population comes under Medi-Cal disenrollment rules. (STC Page 27, Paragraph 62.a-b)

**Standard Low Income Health Program Benefits**

MCE core benefits must be provided. (STC Page 27, Paragraph 63.a)

**HCCI population core benefits**

HCCI core benefits are more limited than the MCE core benefits and do not include the following benefits for HCCI recipients: Mental health benefits are described in STCs 64 and 65, prior authorized non-emergency medical transportation (when medically necessary, required for obtaining medical care and provided for the lowest cost mode available), and podiatry. (STC Page 27, Paragraph 63.b)

**Excluded Benefits (both MCE and HCCI)**

The three benefits listed, organ transplants, bariatric surgery, and infertility, are excluded services for both the MCE and HCCI populations. (STC Page 28, Paragraph 63.c)

**Enhancements to Core Benefits**

The State will submit to CMS for approval proposals from counties to provide benefits that include additional Medicaid eligible services above minimum core benefits and receive Federal funding. Counties will have to submit proposals to the State to obtain CMS approval for these additional benefits. (STC Page 28, Paragraph 63.d)

**Denial of Services**

The LIHP may exclude out-of-network services from the core benefits listed in paragraph 63. a and b, except for medically necessary emergency services and/or required post stabilization care. (STC Page 28, Paragraph 63.f)

**Coverage of Out-of-Network Emergency Services**

Counties must provide coverage for hospital –based emergency care and consequent post-stabilization care, meeting the definitions under STC Paragraph 63.f.iii, whether the care is rendered in or outside the county network. Other than medically necessary emergency services (including emergency transportation) and/or required post stabilization care, the county may deny coverage for any other service provided outside the LIHP. (STC Page 28, Paragraph 63.f)

**Payment for Emergency Services**

The payment provision limits the LIHP financial liability in instances of emergency and post-stabilization service provided by out of network hospitals. However, this payment to hospitals is contingent on the hospital satisfaction of two conditions (Paragraph 63.f.ii): (1) making notification to the LIHP of the patient's emergency visit and (2) adhering to LIHP protocols for approval of post stabilization services. Emergency room care, other than meeting the definition of emergency, is not addressed. The out-of-network provider must accept LIHP payments made in accordance with these STCs as payment in full. LIHP recipients are not liable for payment. (STC Page 28, Paragraph 63.f.i)

**Notification by Out of Network Provider**

To receive payments for emergency services, a hospital must provide the required notification to the LIHP and comply with the LIHP's inpatient, post stabilization, service authorization protocols. (STC Page 28, Paragraph 63.f.ii)

## **LIHP Plan Materials**

Information provided to recipients will include coverage for emergency and/or post stabilization services at out of network hospitals and the recipient's right not to be financially liable. (STC Page 29, Paragraph 63.h)

## **MCE Mental Health Benefit Criteria**

The MCE recipient must be diagnosed by a MCE provider with a mental health diagnosis specified in the Diagnostic and Statistical manual (DSM). The MCE recipient must also have at least one of the listed impairments and the recommended intervention must be reasonably calculated to significantly diminish the impairment or prevent significant deterioration in an important area of life functioning. Additional criteria listed in paragraph 64.c.i may also apply for inpatient admission. (STC Page 29, Paragraph 64.a-64.c)

## **Mental Health Benefits for MCE Enrollees**

Mental health benefits are included in the core benefits for MCE recipients but are not required for HCCI

For MCE enrollees, each county must provide the following minimum package of mental health benefits:

- Up to 10 days per year of acute inpatient hospitalization in an acute care hospital, psychiatric hospital, or psychiatric health facility.
- Psychiatric pharmaceuticals.
- Up to 12 outpatient encounters per year. Outpatient encounters include assessment, individual or group therapy, crisis intervention, medication support and assessment. If a medically necessary need to extend treatment to an enrollee exists, the plan can optionally expand the service(s). (STC Page 29, Paragraph 65)

## **Mental Health Benefits for MCE Enrollees – Benefits Beyond the Minimum**

Proposals to provide mental health benefits that include additional Medicaid eligible services above the minimum and receive Federal funding must be submitted by the State to CMS for approval. (STC Page 29, Paragraph 65.b)

## **Mental Health Benefits for MCE Enrollees – Option to carve out Mental Health Benefits**

Participating counties may use a separate mental health system through which to provide mental health services. (STC Page 29, Paragraph 65.c)

## **Behavioral Health**

The design and assessment of behavioral health needs are obligations of the State. Additionally, the State will submit a plan to CMS for approval. (STC Page 30, Paragraph 66, 67, and 68)

## **Other**

### **Cost Sharing Parameters for the LIHP Population**

MCE related enrollment fees and premiums must be discontinued for enrollees with family income at or below 133 percent of the FPL and newly participating MCE program counties must comply with Medicaid cost sharing limits for MCE and HCCI populations. (STC Page 30, Paragraph 70.a-.b)

As of July 1, 2011, all cost-sharing must be in compliance with Medicaid requirements for LIHP populations. Additionally, all HCCI enrollees must be limited to a 5% aggregate cost sharing limit per family. (STC Page 30, Paragraph 70.a-.b)

### **Delivery Systems for the LIHP population**

A county based delivery system with a closed network of providers is considered a managed care delivery system. (STC Page 30, Paragraph 71)

### **Network Adequacy and Access Requirements for the LIHP Population**

Any managed care entity must comply with network adequacy and access requirements. The State must ensure compliance with network adequacy and access requirements. (STC Page 31, Paragraph 72)

### **Primary Health Care Services-Accessibility**

- Accessibility to primary health care services will be provided at a location within 60 minutes or 30 miles from each enrollee's place of residence.
- Primary care appointments will be made available within 30 business days of request during the period of the Demonstration term through June 30, 2012 and within 20 business days during the Demonstration term from July 1, 2012 through December 31, 2013.
- Urgent primary care appointments will be provided within 48 hours (or 96 hours if prior authorization is required) of request. Urgent care means services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (i.e., sore throats, fever, minor lacerations, and some broken bones). . (STC Page 31, Paragraph 72.a)

### **Specialty Health Care Services-Accessibility**

Specialty care access will be provided at a minimum within 30 business days of request. (STC Page 31, Paragraph 72.b)

### **Office Hours of Network Providers**

Network providers must offer office hours at least equal to those offered with the health plan's commercial line of business or Medi-Cal fee-for-service participants. Services under the contract must be made available 24 hours per day, seven days per week when medically necessary. The State, through managed care entity contracts, must establish mechanisms to ensure and monitor provider compliance and must take corrective action when noncompliance occurs. (STC Page 31, Paragraph 72.c)

## **Los Angeles County**

LIHP recipients in sparsely populated areas of Los Angeles County may be afforded appropriate transportation services to the nearest (non-public) network hospital when required to obtain medical care. (STC Page 31, Paragraph 72.e)

## **FQHCs**

Federally Qualified Health Center (FQHC) means an entity defined in Federal law. To serve the LIHP population, a county must contract with at least one FQHC and pay the prospective payment system (PPS) rate. (STC Page 31, Paragraph 72.f)

## **LIHP Credentialing and Cultural Competence**

The State must ensure that providers are appropriately credentialed and promote culturally competent service delivery. (STC Page 32, Paragraph 73)

## **Encounter Data**

Each LIHP county will be responsible for collection and reporting of data on services provided to recipients according to mechanisms developed by the State. (STC Page 32, Paragraph 74)

## **Due Process**

In addition to any county-administered grievance process, the State must implement standards and procedures for fair hearings and appeals. (STC Page 32, Paragraph 76)

## **Medi-Cal Managed Care Contract Information**

Medi-Cal managed care criteria and standards for health plans are set forth in statutes, regulations, and policies adopted by the DHCS. The requirements for an acceptable delivery system to serve Medi-Cal managed care beneficiaries are expressed in the Medi-Cal managed care contract. A sample two plan managed care contract is available at [http://www.dhcs.ca.gov/provgovpart/Documents/MMCD\\_Two-Plan\\_Boilerplate.pdf](http://www.dhcs.ca.gov/provgovpart/Documents/MMCD_Two-Plan_Boilerplate.pdf). Portions of the Medi-Cal managed care contract that reference subjects included in this summary are listed below:

### **Attachments:**

- Attachment 1: Access and Availability- Medi-Cal managed care requirements for access and availability standards.
- Attachment 2: Provider Network, Provider Relations, and Provider Compensation - Medi-Cal managed care requirements for FQHC reimbursement.
- Attachment 3: Credentialing- Medi-Cal managed care requirements for credentialing.
- Attachment 4: Cultural and Linguistic Competence - Medi-Cal managed care requirements for culturally competent services.
- Attachment 5: Encounter Data (Management Information System) - Medi-Cal managed care requirements for submission of encounter data.
- Attachment 6: Scope of Services – Medi-Cal managed care benefits and exclusions.
- Attachment 7: Utilization Management – Medi-Cal managed care requirements for a utilization management program.

- Attachment 8: Medi-Cal Managed Care Definitions - Medi-Cal managed care definitions for emergency medical condition, emergency services, and post stabilization care services
- Attachment 9: Written Member Information - Medi-Cal managed care requirements for member written information.
- Attachment 10: Grievances and State Fair Hearing - Medi-Cal managed care requirements for State fair hearing process.